Superior Court of California, County Juvenile Dependency Court
Dependency Recovery Drug Court
Perris, California
TI14344

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PROJECT DESCRIPTION

Expansion or Enhancement Grant—Enhancement

Program Area Affiliation—Drug Court (Criminal Justice)

Congressional District and Congressperson—California 43; Ken Calvert

Public Health Region—IX

Purpose, Goals, and Objectives—This project is a collaboration between Riverside County Courts and the Dependency Recovery Court Committee. The purpose of the proposed project is to enhance Riverside's Dependency Drug Court program so that it provides more timely and effective treatment to substance-abusing parents at risk of losing custody of their children. The overall goal of the project is to establish an integrated, court-based collaboration that protects children from abuse and neglect precipitated by substance abuse in the family through the provision of coordinated services, substance abuse treatment, and safe and permanent placements. (abstract; page 10)

Target Population—The target population for the proposed program will be young parents, 18 years of age and older with children (ages 0 to 5 years), who live in Riverside County and have not been successful in helping themselves and their families. (page 11)

Geographic Service Area—The geographic service area is Riverside County, California. The County receives close to 20,000 reports of suspected child abuse or neglect each year. Of these cases, the dependency court provides protection to children found to be neglected or abused. County statistics show that approximately 80 percent of these dependency cases involve substance abuse by one or both parents, with approximately 60 percent of the children receiving out-of-home placements. The ethnic breakdown of the county is 51 percent white, 36 percent Hispanic, 6 percent African American, and 7 percent from other ethnic backgrounds. Entry into the county's dependency court in 2001 followed a similar pattern, with whites making up the majority of clients, followed by Hispanic, then African American clients. (pages 9–11)

Drugs Addressed—Seventy percent of drug offenders claim methamphetamine as their primary drug of choice, with marijuana second. Large-scale methamphetamine production in Riverside County skyrocketed between the years 2000 and 2001, and the result of this increased production is reflected in the number of drug-related arrests. (page 10)

Theoretical Model—The proposed project will build on the concept of family strengthening using the Kumpfer (1994) model curriculum, Strengthening Families. This model focuses on changing parent behaviors through the cognitive restructuring of parent–child communication and family management skills. In examining family models with proven effectiveness among substance-abusing parent populations, the project steering committee selected a curriculum called the Nurturing Program for Infant to 5 (Bavelock and Spoth, 1996). (page 16)

Type of Applicant—State (SF-424, item #7)

SERVICE PROVIDER STRUCTURE

Service Organizational Structure—As previously mentioned, this project is a collaboration between the Riverside County Court (RCC) Family Treatment Drug Court (FTDC) and the Dependency Recovery Drug Court (DRDC). The DRDC will serve as the lead agency and project steering committee for the proposed program. The steering committee membership consists of probation officers, treatment providers, a judge, a district attorney, and employees of the Department of Public Social Services (DPSS). The committee will be responsible for assuring that the operational plan is followed and will take an active role in guiding the future course of the proposed program. The RCC implemented the first criminal adult drug court in 1995. Currently, the RCC runs three adult drug courts, one mental health drug court, one family court, and one juvenile delinquency drug court. This project will be Riverside's first collaboration to form a drug court for juvenile dependency. (pages 18, 29)

Service Providers—Several partner agencies will be involved in implementing the proposed program. Although not clear in the project narrative, the role of each partner is unequivocally stated in a signed memorandum of understanding that is included in the application. The partners and a condensed description of the program services they will provide are as follows:

- Riverside County Department of Mental Health Substance Abuse Program (DMH/SAP)—substance abuse treatment, including intensive case management
- Riverside County Department of Mental Health (DMH)—mental health assessments of the parent and child and development of treatment plans
- Department of Public Social Services (DPSS)—case management of the reunification process, including monitoring child welfare and safety; and maintaining communication with the participant's substance abuse treatment counselor
- County Counsel and Juvenile Defense Panel—public safety while also protecting the participant's right to due process; collaboration with case managers to ensure client participation in the program; and recommendation to the DRDC regarding participant progress and reunification

(pages 119–122)

Services Provided—The proposed DRDC is designed with many of the same characteristics as drug courts that operate in criminal or family law. However, in the proposed program, case supervision by the court will be intensified to ensure that reunification goals are met. Where cases are typically reviewed every 6 months before the court, the proposed program will review cases weekly, bi-monthly, or monthly, depending on the parent's compliance with the service objectives, which will be based on an objective point system.

The drug court judge will review the eligibility criteria for each parent upon entry into the court system. Once deemed eligible, the parent and child will undergo an intake process that includes psychological assessment and treatment as determined by a clinical therapist, as well as a physical health/medical examination. Following intake and the judge's order for the client to enter Family Treatment Drug Court (FTDC), the client and his/her child will each be assigned to a behavioral specialist. The behavioral specialist for the parent will provide intensive substance abuse and mental health treatment, case management, and monitoring of the client's progress and provide support for the parent in his/her progress toward reunification. The behavioral specialist for the child will primarily serve as child advocate, working with parents to enhance visitation services and to develop a plan to help strengthen parents' relationship with their children.

Client placement in a treatment program will be determined by the severity of the addictive disorder. Although it is not clear what the treatment modality options are, level of treatment will be determined using the American Society for Addiction Medicine (ASAM) placement criteria. Regardless of treatment modality, all services will include housing, employment, legal services, and adult education. The child will receive referrals to services recommended by DPSS, such as mental health assessment, group counseling, and play therapy. Successful treatment completion will be defined as the parent having obtained a GED (if needed) and full or part-time employment, and maintaining a clean and sober living environment. Upon completion, the determination will be made as to whether the child will stay with or be returned to the parent(s). If the parent has successfully completed treatment and it is safe to do so, the child will be returned to/remain with the parents to eliminate or minimize the adverse effects associated with removal. (pages 15–17)

Service Setting—A complete list of DMH/SAP facilities includes several treatment modalities, from detoxification to residential to HIV intervention, all in non-hospital settings. However, although it is not clear, by definition it appears that drug court will be the only modality used in the proposed project. Drug court services are defined as follows: Structured substance abuse treatment provided to participants referred by the courts who are charged with a felony or misdemeanor drug-related offense combined with a prior verifiable history of substance abuse. (pages 80–92, 97)

Number of Persons Served—Because of resource constraints, the maximum caseload for the first 12 months of the program will be 40 families. However, 60 families per year will be served in each of Years 2 and 3. The project does not provide an explanation for why 20 fewer families will be served in Year 1. (page 20)

Desired Project Outputs—Desired project outputs are listed as follows:

- Improved accessibility to residential substance abuse treatment and mental health services for participating families
- Improved parental functioning and care for their children through the provision of education and employment services
- Reduced frequency and duration of out-of-home placements
- Increased retention in drug treatment
- Reduced number of reports of child abuse/neglect
- Reduced substance abuse
- Reduced criminal activity
- Reduced parental stress and depression

(page 12)

Consumer Involvement—Near the end of the project narrative, it is stated that the steering committee meetings and consumer advisory group will meet regularly. There is no other mention of consumer involvement in the application. (page 28)

EVALUATION

Strategy and Design—The evaluation will consist of a process and an outcome component. The process evaluation will be primarily qualitative in nature, although quantitative information will be incorporated where appropriate (e.g., client satisfaction surveys). All interim process

evaluation findings will be continuously reported to program staff in order to improve the quality of services. The outcome evaluation will use a rigorous, quasi-experimental design with repeated measures (pre-test, post-test, and two follow-up intervals) to provide certainty about the efficacy of the program. Assignment to the treatment group will be on a first-come, first-served basis, and when maximum caseload has been reached other eligible families will be assigned to the comparison group. Reliability and validity checks will also be conducted. All outcome data will be checked for internal consistency of the proposed measurement scales using Cronbach's alpha statistic. Correlational analyses will be performed to examine simple linear relationships among variables and to estimate construct validity. (pages 19–20, 22–23)

Evaluation Goals/Desired Results—The goals of the process evaluation are to (1) describe how the project enhances the dependency drug court, (2) detect barriers to program implementation, (3) track intervention modifications, and (4) monitor the effects of the proposed modifications. The primary goal of the outcome evaluation is to test the effectiveness of the proposed program on the well-being of parents enrolled in substance abuse treatment, along with the well-being of their children and families. (page 20)

Evaluation Questions and Variables—The evaluation questions are clearly stated in the application by process or outcome component. The following are process evaluation questions:

1. How does the project enhance the dependency drug court?
2. What are the barriers to the implementation and effectiveness of the program?
3. What policies and procedures were modified to improve the effectiveness of the program?

Outcome evaluation questions are as follows:

1. Does the dependency drug court reduce the frequency and duration of out-of-home placements?
2. Do the dependency drug court services improve the well-being of the children of parents enrolled in the program?
3. Do the dependency drug court services improve the well-being of parents enrolled in the program?
4. Do the dependency drug court services improve family functioning?

(pages 26–27)

Key variables for adults include substance abuse and substance abuse treatment history; physical health; criminal involvement, history, and risk to re-offend; family and social history and living situation; employment and work skills; educational level; financial status; and housing and transportation needs. Child data are not specifically listed, but a couple of primary variables can be inferred from the child-related evaluation questions and the data sources listed below, i.e., substantiated incidents of child abuse/neglect and mental health status. (pages 13–14, 21, 26)

Instruments and Data Management—All of the child outcome measures used in the evaluation will come from administrative sources. These measures include (1) subsequent reports of child abuse/neglect, (2) progress reports and case notes, and (3) number of referrals to mental health services. Adult measures will include toxicology screen results and administration of several standardized assessment tools, all of which will be administered at intake and at 6-, 12-, and 18-month follow-up intervals. The instruments are as follows:

- Government Performance Reporting Act Core Client Outcomes measure (Note: The project lists the GPRA instrument as the "GPRA Parent Questionnaire.")
- Addiction Severity Index (ASI)
- Beck Depression Inventory (BDI)
- Perceived Stress Scale (PSS)
- Family Environment Scale (FES)

(pages 21–22, 27)

SPSS statistical software will be used to build the project database and generate frequency data to identify legitimate data values, inconsistencies, and data entry problems. This database will then be converted into a Microsoft Excel spreadsheet for use by providers and collaborating service agencies that will use the spreadsheet format to enter client data onsite. All outcome data will be entered and cleaned, and double-entry procedures will be used to check for coding errors. Random spot checks of data will also be performed to ensure quality control. (pages 22–23)